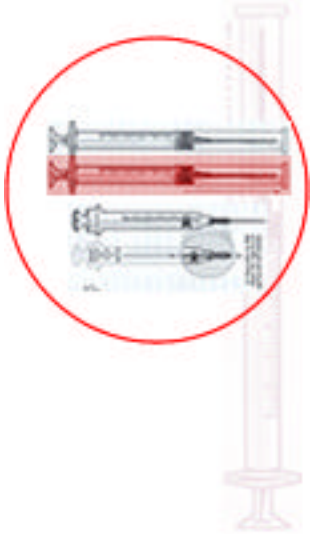
NIOSH recommends that health care facilities use safer medical devices to protect workers from needlestick and other sharps injuries. Since the passage of the Needlestick Safety and Prevention Act in 2000 and the subsequent revision of the OSHA Bloodborne Pathogen Standard, all health care facilities are required to use safer medical devices.

SAFER MEDICAL DEVICE IMPLEMENTATION IN HEALTH CARE FACILITIES

SHARING LESSONS LEARNED

NIOSH has asked a small number of health care facilities to share their experiences on how they implemented safer medical devices in their settings. These facilities have agreed to describe how each step was accomplished, and also to discuss the barriers they encountered and how they were resolved, and most importantly, lessons learned.



Phase 2 Report-Identify Priorities

The Department of Dentistry is a unit of a multi-site, public healthcare system. The system includes a 728 bed main campus teaching hospital and outpatient-based patient services. The system also includes 12 satellite outpatient locations. Dentistry sees patients at four sites: the main campus of the medical center, two satellite health centers and a skilled nursing center.

In order to identify priorities, I used several means, both formal and informal for assessing risk. The institution tracks needlesticks that are reported and followed through Employee Health. I looked at the Needlestick data contained in these reports for Dentistry. I also looked at Incident Reports that were generated by staff and may or may not have resulted in a visit to Employee Health. In addition I interviewed staff regarding sharps injuries.

The formal Needlestick Report reported only a few needlesticks per year for the dental staff. A review of the Incident Reports for the same time period indicated that in addition to "needlesticks" there were an equal number of "sticks" by endodontic files. Thirdly staff interviews showed that there were sticks with clean or uncontaminated needles and endodontic files that were not reported.

Based on the above information, it was decided that we would focus on products that would decrease the incidence of sharps injuries from syringes and needles used for local anesthetics. In addition we decided to investigate some engineering controls that could be put in place to decrease the risk of sharps injuries from endodontic files.

From this process I learned that many injuries from sharps are not reported. Most of the time, the unreported injuries are secondary to being stuck with something that is thought to be "clean" or uncontaminated. For instance if a staff member is stuck with an endodontic file that has been presoaked in a disinfectant or ultrasonic cleaner prior to sterilization, this would probably be classified as uncontaminated by the employee. This injury may not be reported.

The Sharps Team was an integral aspect if this process as they were able to focus on the issues that were the most problematic and set some priorities that could be planned and implemented expediently. I found the informal discussions with staff to be the most helpful aspect of this phase of our process.

Staff Hours

Type of Staff	Hours Spent on Phase 1
Management	3
Administrative	25
Front-line	5
Total	33

Other, non-labor items:

Item
1. Review institutional and department reports
2. Internet Search regarding Dental Sharps Injuries
3. Interviews/Discussions with staff